Senate

General Assembly

File No. 337

January Session, 2017

Substitute Senate Bill No. 426

Senate, March 30, 2017

The Committee on Insurance and Real Estate reported through SEN. LARSON of the 3rd Dist. and SEN. KELLY of the 21st Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING CONTRACTS BETWEEN HEALTH CARRIERS AND HEALTH CARE PROVIDERS, AGENTS OR VENDORS, PARTICIPATING PROVIDER DIRECTORIES AND SURPRISE BILLS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-477f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) On and after January 1, **[**2016**]** 2018, no contract entered into or renewed between a health care provider, or any agent or vendor of a health care provider, and a health carrier shall contain a provision prohibiting disclosure of (1) billed or allowed amounts, reimbursement rates or out-of-pocket costs, **[**and**]** or (2) any data to the all-payer claims database program established under section 38a-1091. **[**for the purpose of assisting**]** Information described in subdivisions (1) and (2) of this subsection may be used to assist consumers and institutional purchasers in making informed decisions regarding their health care and informed choices among health care providers and allow

comparisons between prices paid by various health carriers to health care providers.

(b) If a contract described in subsection (a) of this section contains a provision prohibited under said subsection, the provision shall (1) be void and unenforceable, and (2) constitute an unfair method of competition and unfair or deceptive practice prohibited by sections 38a-815 to 38a-819, inclusive. The invalidity or unenforceability of any contract provision under subdivision (1) of this subsection shall not affect any other provision of the contract.

Sec. 2. Section 38a-477h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section: (1) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa, as amended by this act, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f.

(b) (1) Each health carrier shall post on its Internet web site a current and accurate participating provider directory, updated at least **[**monthly**]** weekly, for each of its network plans. The health carrier shall ensure that **[**consumers are able to**]** any person may view, without any restrictions or limitations, all of the current participating providers for a network plan through a clearly identifiable link or tab on such health carrier's Internet web site. **[**, without being required to create or access an account or enter a policy or contract number.**]** The directory shall be accessible without any requirement that the individual seeking to access the directory (A) demonstrate coverage under the underlying network plan, (B) indicate interest in obtaining coverage under such plan, (C) create or access an account, (D) enter a policy or contract number, or (E) provide any other personally identifiable information.

(2) Each health carrier shall provide, upon request from [a covered] any person, [or a covered person's representative,] a print copy of such directory or of requested information from such directory. Such print copy shall be provided to the person requesting such copy either (A) in person, or (B) by mail postmarked not later than five business days following the date the request is received by the health carrier. Each health carrier shall update the printed participating provider directory for each of its network plans at least quarterly.

(3) Each contract between a health carrier and a provider participating in a network plan shall require that the participating provider inform the health carrier not later than five business days after the date on which (A) the provider stops accepting new patients enrolled in the plan, or (B) the provider begins accepting new patients enrolled in the plan. Such contract shall provide the participating provider with information and instructions on how to make such notification through the online interface required under subsections (g) and (h) of this section.

(c) (1) A health carrier shall include in each such electronic or print directory the following information in plain language: (A) A description of the criteria the health carrier used to build its network; (B) if applicable, a description of the criteria the health carrier used to tier its participating providers; (C) if applicable, a description of how the health carrier designates the different participating provider tiers or levels in the network and identifies, for each specific participating provider, in which tier each is placed, such as by name, symbols or grouping, to allow a consumer to be able to identify the participating provider tiers; and (D) if applicable, a statement that authorization or referral may be required to access some participating providers.

(2) Each such directory shall also include a customer service electronic mail address, [and] telephone number [or] and an Internet web site address that covered persons or consumers may use to [notify] report to the health carrier [of] any inaccurate participating provider information in such directory. The health carrier shall

promptly investigate any such report by, among other things, contacting the affected health care provider not later than five business days after submission of the report. The health carrier shall take corrective action, if necessary, not later than thirty days after submission of the report to ensure that the affected provider directory is accurate.

(3) Each health carrier shall make it clear for each such electronic or print directory which directory applies to which network plan, such as by including the specific name of the network plan as marketed and issued in this state.

(4) Each such electronic or print directory shall accommodate the communication needs of individuals with disabilities and include an Internet web site address or information regarding available assistance for individuals with limited English proficiency.

(d) (1) The health carrier shall make available through an electronic participating provider directory, for each of its network plans, the following information in a searchable format:

(A) For health care providers, (i) the health care provider's name, gender, participating office location or locations, specialty, if applicable, medical group affiliations, if any, facility affiliations, if applicable, participating facility affiliations, if applicable, (ii) any languages other than English spoken by such health care provider, and (iii) whether such health care provider is accepting new patients;

(B) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer, the participating hospital location and the hospital's accreditation status; and

(C) For facilities other than hospitals, by type, the facility name, the facility type, the types of health care services performed at the facility and the participating facility location or locations and telephone number or numbers.

(2) In addition to the information required under subdivision (1) of

this subsection, the health carrier shall make available through the electronic directory specified under subdivision (1) of this subsection, for each of its network plans, the following information:

(A) For health care providers, the health care provider's contact information, board certification and any languages other than English spoken by clinical staff, if applicable;

(B) For hospitals, the hospital's telephone number; and

(C) For facilities other than hospitals, the facility's telephone number.

(3) (A) Each health carrier shall make available in print, upon request, the following participating provider directory information for the applicable network plan:

(i) For health care providers, (I) the health care provider's name, contact information, specialty, if applicable and participating office location or locations, (II) any languages other than English spoken by such health care provider, and (III) whether such health care provider is accepting new patients;

(ii) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer and the participating hospital location and telephone number; and

(iii) For facilities other than hospitals, by type, the facility name, the facility type, the types of health care services performed at the facility and the participating facility location or locations and telephone number or numbers.

(B) Each health carrier shall include with the print directory information under subparagraph (A) of this subdivision and in the print participating provider directory under subdivision (2) of subsection (a) of this section a statement that the information provided or included is accurate as of the date of printing, that covered persons or prospective covered persons should consult the health carrier's

electronic participating provider directory on such health carrier's Internet web site and that covered persons may call the telephone number on such covered person's insurance card for more information.

(4) For the information required to be included in a participating provider directory pursuant to subdivisions (1) and (2) of this subsection, each health carrier shall make available through such directory the sources of such information and any limitations on such information, if applicable.

(e) Each health carrier shall, **[**periodically**]** at least annually, audit **[**at least**]** a reasonable sample size of its participating provider directories for accuracy and retain and provide documentation of such audit **[**to be made available**]** to the commissioner upon request.

(f) Each health carrier shall report to the commissioner, in accordance with timeframes and other requirements established by the commissioner, but at least annually, (1) the number of reports the health carrier received under subdivision (2) of subsection (c) of this section, the name and location of each provider affected by each such report, a description of the nature and timeliness of the carrier's investigation into each such report, and the corrective action taken, if any, in response to each such report, and (2) information concerning the most recent audit conducted pursuant to subsection (e) of this section including, but not limited to, the methodology, sample size and findings thereof, and the responses thereto.

(g) Each health carrier shall take appropriate steps to ensure that the information contained in its provider directories is accurate and shall, at least annually, conduct a comprehensive review of the directory for each of its network plans. Each health carrier, as part of such comprehensive review, shall update and send written notice to each participating provider concerning (1) the processes the health carrier uses to notify each participating provider of the information contained in the directory, (2) the information contained in the directory concerning the provider, (3) instructions concerning the process by which each such provider can update or correct such information

using an online interface, and (4) a list of all network plans that include the provider as a participating provider.

(h) Each health carrier shall implement processes to allow providers to promptly verify and submit changes to the information in provider directories. Such processes shall, at a minimum, include an online interface for providers to electronically submit verification of changes and shall generate an acknowledgment of receipt of such verification from the health carrier.

(i) If a covered person reasonably relied upon materially inaccurate, incomplete or misleading information contained in a health carrier's participating provider directory concerning health care services provided to such covered person, the health carrier shall cover all health care services provided to such covered person as covered services as if such inaccurate, incomplete or misleading information were correct and shall reimburse such covered person for any costs that exceed the costs the covered person would have incurred had the services been provided by a participating provider.

Sec. 3. Section 38a-477aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) As used in this section:

(1) "Emergency condition" has the same meaning as "emergency medical condition", as provided in section 38a-591a;

(2) "Emergency services" means, with respect to an emergency condition, (A) a medical screening examination as required under Section 1867 of the Social Security Act, as amended from time to time, that is within the capability of a hospital emergency department, including ancillary services routinely available to such department to evaluate such condition, **[**and**]** (B) such further medical examinations and treatment required under said Section 1867 to stabilize such individual, that are within the capability of the hospital staff and facilities, and (C) any further medically necessary hospital services

provided as part of the same continuous episode of care and admission to treat the emergency condition;

(3) "Health care plan" means an individual or a group health insurance policy or health benefit plan that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

(4) "Health care provider" means an individual licensed to provide health care services under chapters 370 to 373, inclusive, chapters 375 to 383b, inclusive, and chapters 384a to 384c, inclusive;

(5) "Health carrier" means an insurance company, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues a health care plan in this state;

(6) (A) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider (i) at an in-network facility, (ii) during a service or procedure performed by an in-network provider, (iii) or during a service or procedure previously approved or authorized by the health carrier, **[**and the insured did not knowingly elect to obtain such services from such out-of-network provider**]** or (iv) upon the referral of an in-network provider and without the express written consent of the insured acknowledging that the in-network provider is referring the insured to an out-of-network provider and that the referral may cause the insured to incur costs not covered by the health carrier.

(B) "Surprise bill" does not include a bill for health care services received by an insured when (i) an in-network health care provider was made available to the insured to render such services, **[**and**]** (ii) the insured knowingly **[**elected**]** and voluntarily consented, in writing, to obtain such services from another health care provider who was out-of-network and acknowledged, in writing, that such services might

result in costs not covered by the health carrier, and (iii) for scheduled health care services, the health care provider obtained such written consent on the earlier of: (I) The date on which the health care provider, or any person on behalf of such provider, scheduled a date for the provider to render such services to the insured; (II) the date on which the health care provider first discovered that the provider is an out-of-network provider; or (III) forty-eight hours before the health care provider rendered such services to the insured.

(b) (1) No health carrier shall require prior authorization for rendering emergency services to an insured.

(2) No health carrier shall impose, for emergency services rendered to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider.

(3) (A) If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall, within thirty days, reimburse such health care provider the greatest of the following amounts: (i) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (ii) the usual, customary and reasonable rate for such services; or (iii) the amount Medicare would reimburse for such services. As used in this subparagraph, "usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. Such organization shall not be affiliated with any health carrier.

(B) Nothing in this subdivision shall (i) be construed to prohibit such health carrier and out-of-network health care provider from

agreeing to a greater reimbursement amount, or (ii) constitute a waiver of any right of either party, including any right to dispute the reimbursement provided pursuant to this subdivision.

(c) With respect to a surprise bill:

(1) An insured shall only be required to pay the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for such health care services if such services were rendered by an in-network health care provider; and

(2) **[**A**]** (A) An out-of-network provider may bill the health carrier directly for the services rendered. The health carrier shall, not later than thirty days after the out-of-network health care provider billed such carrier for such services, reimburse the out-of-network health care provider **[**or insured, as applicable,**]** for the health care services rendered **[**at the in-network rate under the insured's health care plan as payment in full, unless such health carrier and health care provider agree otherwise.**]** at the billed amount or, if the health carrier determines that the billed amount is unreasonable, an amount that is not less than the average in-network rate paid to similarly qualified health care providers for the same services in the same region.

(B) Nothing in this subdivision shall (i) be construed to prohibit a health carrier or out-of-network health care provider from agreeing to a different reimbursement amount, or (ii) constitute a waiver of any right of either party, including any right to dispute the reimbursement provided pursuant to this subdivision.

(d) If health care services were rendered to an insured by an out-of-network health care provider and the health carrier failed to inform such insured, if such insured was required to be informed, of the network status of such health care provider pursuant to subdivision (3) of subsection (d) of section 38a-591b, the health carrier shall not impose a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such services were

rendered by an in-network health care provider.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2018*	38a-477f
Sec. 2	*October 1, 2017*	38a-477h
Sec. 3	*January 1, 2018*	38a-477aa

Statement of Legislative Commissioners:
In Section 1(a), "**[**for the purpose of**]** Such information described in subdivisions (1) and (2) of this subsection may be used for purposes such as assisting" was changed to "**[**for the purpose of assisting**]** Information described in subdivisions (1) and (2) of this subsection may be used to assist" for clarity.

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 18 $	FY 19 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Plan)	GF&TF - Potential Cost	See Below	See Below
Attorney General	GF- Potential Revenue Gain	See Below	See Below

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 18 $	FY 19 $
Various Municipalities	STATE MANDATE - Potential Cost	See Below	See Below

Explanation

The bill may result in a cost to the state employee and retiree health plan[1] and fully-insured municipal plans to comply with the coverage and reimbursement requirements in sections 2 and 3 of the bill. Section 2 of the bill requires the carrier (e.g. the state for the state plan) to provide coverage for "all services provided to such covered person" as a "covered service" if the individual relied on inaccurate information to select their provider. In practice a carrier's provider directory does not customarily provide a list of covered services. For the state plan, the Health Plan Benefit Document provides the plan's covered services, exclusions, and other detailed information on the

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

plan's benefits. If section 2 is interpreted to require carriers to reimburse for services in certain circumstances, not otherwise covered at a non-network provider the state and municipalities will incur additional costs for those services not covered by the plan.

Section 3 requires the carrier to reimburse the non-network provider at the (1) in network rate; the (2) billed amount, or (3) the average in-network rate paid to similarly qualified providers if the carrier determines the billed amount is "unreasonable". It is unclear what "unreasonable" means; if this condition is not met and the carrier is required to reimburse the non-network provider at the billed amount, the state and municipal plans will incur additional costs. Under the state health plan, the carrier's obligation is limited to paying a non-network provider 80% of the "usual and customary" charge for such a service. Under the bill the full "billed" cost could be passed on to the state or municipality.

In addition, section 3 of the bill changes the definition of "emergency services" to include any further medically necessary hospital services provided as part of the same continuous episode of care and admission to treat the emergency condition. The state plan currently requires prior authorization of inpatient hospital services. To the extent this provision of the bill preempts the prior authorization policy used to manage utilization of services there may be an additional cost to the state and municipalities. The state plan does not currently require prior authorization for emergency services under current law.

As previously stated, the bill may result in a cost to fully-insured municipal plans to the extent the provisions of the bill result in increased premium costs for the municipality when they enter into new health insurance contracts after January 1, 2018. Due to federal law, municipalities with self-insured plans are exempt from state health insurance mandates. Lastly, many municipal plans may be

recognized as "grandfathered"[2] plans under the federal Affordable Care Act (ACA). It is uncertain what the effect of this mandate will have on the grandfathered status of those municipal plans.

Lastly, the bill may result in a revenue gain to the General Fund to the extent additional fines or penalties are assessed for violations of the Connecticut Unfair Insurance Practices Act. The oversight and enforcement of the terms of the bill are not anticipated to result in a fiscal impact to the Department of Insurance (DOI), as the agency already has the expertise.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future and will be reflected in future premiums and premium equivalents.

Source *Office of the State Comptroller State Health Plan, Plan Benefit Document as of September 2016*

[2] Grandfathered plans include most group health insurance plans and some individual plans created or purchased on or before March 23, 2010.

OLR Bill Analysis

sSB 426

AN ACT CONCERNING CONTRACTS BETWEEN HEALTH CARRIERS AND HEALTH CARE PROVIDERS, AGENTS OR VENDORS, PARTICIPATING PROVIDER DIRECTORIES AND SURPRISE BILLS.

SUMMARY

This bill makes changes to the insurance statutes concerning (1) contracts between health carriers (e.g., insurers or HMOs) and health care providers (i.e., provider contracts); (2) carriers' provider directories; and (3) coverage of emergency services and surprise bills.

The bill makes void, unenforceable, and subject to penalty under the Connecticut Unfair Insurance Practices Act (CUIPA) (see BACKGROUND) any provider contract provision that prohibits disclosure of certain specified data, including billed amounts and reimbursement rates. It requires provider contracts to require that providers notify carriers within five days after they start or stop accepting new patients.

With respect to provider directories, the bill requires carriers to, among other things:

1. cover services a person receives based on inaccurate, incomplete, or misleading information in a provider directory as if the directory was correct (e.g., at the in-network level);

2. update online provider directories weekly, instead of monthly, and printed directories at least quarterly;

3. promptly investigate and correct reported provider directory inaccuracies;

4. audit provider directories and conduct a comprehensive review of each one at least annually;

5. report to the insurance commissioner on their investigations and audits; and

6. establish a process for providers to update or correct information in a provider directory using an online interface.

The bill expands the definitions of emergency services and surprise bills and requires carriers to reimburse out-of-network providers who render emergency services or services that result in a surprise bill within 30 days. It also requires providers to obtain express written consent from a patient acknowledging that the patient is being referred to an out-of-network provider and may incur additional costs as a result. For a scheduled health care service, a provider must obtain such written consent from a patient the earlier of when the service is scheduled, when the provider learns the provider is out-of-network, or 48 hours before services are rendered.

EFFECTIVE DATE: January 1, 2018 (§§ 1 & 3), except for the provisions on provider directories and informing carriers if a provider is or is not accepting new patients (§ 2), which are effective October 1, 2017.

§§ 1 & 2 – PROVIDER CONTRACTS

Disclosure of Certain Information Cannot be Restricted (§ 1)

By law, a contract between a health care provider and a health carrier cannot prohibit the disclosure of (1) billed or allowed amounts, reimbursement rates, or out-of-pocket costs or (2) any data to the all-payer claims database (APCD). The Connecticut Health Insurance Exchange (i.e., Access Health CT) administers the APCD.

The bill extends this contract requirement to any contract between a health care provider's agent or vendor and a health carrier that is issued or renewed on and after January 1, 2018.

Under the bill, any provision in a provider contract that prohibits such a disclosure is (1) void and unenforceable and (2) a CUIPA violation.

Informing Carrier that Provider Accepts New Patients or Not (§ 2)

Under the bill, a provider contract must require the provider to inform the health carrier within five days after the provider starts or stops accepting new patients. The contract must include instructions on how the provider can notify the carrier through an online interface.

§ 2 – PROVIDER DIRECTORIES

Covering Services Received Based on Inaccurate Directory

Under the bill, if a person covered by a carrier's network plan reasonably relied upon materially inaccurate, incomplete, or misleading information in a provider directory to receive services, the carrier must cover those services as if the directory was accurate. The carrier must reimburse the covered person for any costs that exceed the costs he or she would have incurred had the services been provided by a participating (in-network) provider.

Making Updated Directories Accessible

By law, a health carrier must post on its website a current, accurate directory of participating providers for each of its network plans and make printed directories available upon request. The bill requires health carriers to update their (1) online provider directories at least weekly, instead of monthly, as under current law, and (2) printed directories at least quarterly.

Under the bill, online directories must be available to anyone without any restrictions or limitations. Existing law requires directories to be accessible without requiring someone to create or access an account or enter a policy or contract number. The bill also specifies that directories must be accessible without any requirement that a person (1) be covered or interested in coverage under the network plan or (2) provide any personally identifiable information.

The bill requires carriers to give a printed provider directory to any person, instead of just covered persons or their representatives, upon request. The carrier must give the copy to the person (1) in person or (2) by mail postmarked within five days after receiving the request.

Investigating Reports of Inaccurate Directory Listing

Under current law, carriers must include in a provider directory a customer service mail address, telephone number, or website address that people may use to report inaccurate directory listings. The bill instead requires a directory to list all three - a customer service mail address, telephone number, and website address.

The bill requires a carrier to promptly investigate any report of an inaccurate directory listing by contacting the affected provider within five business days after receiving the report. It also requires a carrier to correct an inaccuracy within 30 days after receiving a report.

Auditing Directories at least Annually

The bill requires a carrier to audit a reasonable sample size of its provider directories for accuracy at least annually, instead of periodically, as under current law.

Reporting Information to the Insurance Commissioner

The bill requires each health carrier to report to the insurance commissioner in accordance with timeframes and other requirements she may prescribe, but at least annually, information related to inaccurate provider directories and directory audits.

Specifically, a carrier must report the (1) number of reports received of an inaccurate provider directory listing; (2) name and address of each affected provider; (3) nature and timeliness of the carrier's investigation of the report; and (4) corrective action taken, if any. A carrier must also report on the most recent audit conducted, including the methodology, sample size, findings, and action taken as a result.

Verifying Information in Directories with Providers

In addition to the required audit described above, the bill requires

each carrier to ensure that information in its provider directories is accurate by conducting, at least annually, a comprehensive review of each directory. To do this, the carrier must update and send to each participating provider in writing:

1. the process used to notify the provider of the information in the directory,

2. the provider's information in the directory,

3. how the provider can update or correct the information using an online interface, and

4. a list of all network plans that include the provider.

The bill requires each carrier to implement a process that allows a provider to promptly verify and submit changes to information in a provider directory. The process must (1) include an online interface for providers to submit changes electronically and (2) generate a receipt from the carrier to acknowledge it received the information.

§ 3 – EMERGENCY SERVICES AND SURPRISE BILLS

Emergency Services

Under the bill, if an out-of-network provider renders emergency services to a covered person, the health carrier must reimburse the provider within 30 days. Current law does not specify a time period for reimbursement, so presumably such claim payments currently are due within 60 days for a paper claim and 20 days for an electronic claim, pursuant to CGS § 38a-816.

The bill also expands the definition of "emergency services." By law, emergency services are (1) medical screenings to evaluate an emergency condition and (2) further examinations and treatments to stabilize the patient. The bill adds to the definition any further medically necessary hospital services provided as part of the same continuous episode of care and admission to treat the emergency condition.

By law, health carriers cannot require prior authorization for emergency services. The law also prohibits carriers from charging a covered person a coinsurance, copayment, deductible, or other out-of-pocket expense for emergency services performed by an out-of-network provider that is greater than that charged when performed by an in-network provider.

By law, carriers must reimburse out-of-network providers who perform emergency services for covered people the greater of the (1) amount the health care plan would pay if the services were rendered by an in-network provider; (2) usual, customary, and reasonable rate; or (3) amount Medicare reimburses for the services. A carrier and out-of-network provider may agree to a greater reimbursement amount.

The bill specifies that it does not waive any right of the carrier or provider, including any right to dispute the reimbursement amount.

Surprise Bills

The bill changes the definition of "surprise bill." Under current law, a surprise bill is a bill for non-emergency health care services received by a covered person for services rendered by an out-of-network provider at an in-network facility during a service or procedure that was performed by an in-network provider or previously approved by the health carrier for which the covered person did not knowingly elect to receive from an out-of-network provider.

Under the bill, a surprise bill is a bill for non-emergency health care services rendered by an out-of-network provider (1) at an in-network facility, (2) during a service or procedure performed by an in-network provider or previously approved by the carrier, or (3) upon the referral of an in-network provider without the express written consent of the patient acknowledging that the patient is being referred to an out-of-network provider and may incur costs not covered by the carrier (i.e., out-of-pocket costs).

Under the bill, a bill is not a surprise bill if an in-network provider is made available to the covered person and the person knowingly and

voluntarily consents in writing that receiving services from an out-of-network provider may result in out-of-pocket costs. The bill requires a provider, for a scheduled health care service, to obtain a covered person's written consent to receive services from an out-of-network provider at the earlier of (1) when the services are scheduled, (2) when the provider first learns the provider is out of network, or (3) 48 hours before the services are rendered.

By law, if a covered person receives a surprise bill, he or she is only required to pay the coinsurance, copayment, deductible, or other out-of-pocket cost that would apply had an in-network provider rendered the service.

Under the bill, an out-of-network provider who renders services to a covered person that result in a surprise bill may bill the carrier directly.

Under current law, the carrier must reimburse the out-of-network provider or covered person, as applicable, for the services at the in-network rate under the plan as payment in full, unless the carrier and provider agree otherwise (presumably within normal claim payment deadlines). The bill instead requires the carrier to reimburse the out-of-network provider, within 30 days after being billed, the billed amount or, if the carrier determines the billed amount is unreasonable, an amount that is at least the average in-network rate paid to similarly qualified providers for the same services in the same region.

Under the bill, a carrier and out-of-network provider may agree to a different reimbursement amount. And the bill specifies that it does not waive any right of the carrier or provider, including any right to dispute the reimbursement amount.

BACKGROUND

CUIPA

The law prohibits engaging in unfair methods of competition or unfair or deceptive insurance acts or practices. CUIPA authorizes the insurance commissioner to issue regulations, conduct investigations

and hearings, issue cease and desist orders, ask the attorney general to seek injunctive relief in Superior Court, impose fines, revoke or suspend licenses, and order restitution.

Fines may be up to (1) $5,000 per violation to a $50,000 maximum or (2) $25,000 per violation to a $250,000 maximum in any six-month period if knowingly committed. The law also imposes a fine of up to $50,000, in addition to or in lieu of a license suspension or revocation, for violating a cease and desist order (CGS §§ 38a-815 to 38a-819).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 4 (03/15/2017)